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ABSTRACT

This handbook is designed for use by the college level sex educator who attempts preventative counseling related to sexual dysfunction in an office setting. It contains a brief review of current literature related to coitus among single youth which reveals the sociopsychological context of behavior. This discussion includes incidence of coitus among single adolescents and youth, the physiological revolution, cohabitation of college students, norms and sexual behavior, theories explaining sexual intercourse among single young people, anxiety associated with sexual behavior, and contraceptive behavior among sexually active youth. The guide then examines the program of Psychological Services at the State University of New York and office counseling techniques of physicians when dealing with such specific sexual problems as orgasmic dysfunction, vaginal constriction, dyspareunia, promiscuity, impotence, and premature ejaculation. It also discusses communication and education related to sex and sexuality as means of improving sexual functioning, as well as presenting models of sex therapy which provide a background for the sex educator in counseling. A reality therapy model of counseling is developed for the educator in treating immediate causes of sexual dysfunction. A bibliography of 64 books is also included. (Author/BD)

A HANDBOOK RELATED TO OFFICE COUNSELING TECHNIQUES

for the

COLLEGE LEVEL SEX EDUCATOR

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FOREWARD

This handbook is designed for the use of the college level sex educator who attempts preventitive counseling related to sexual dysfunction in an office setting. A brief review of current literature related to coitus among single youth reveals the sociopsychological context of the behavior. Examination of the program of the Psychological Services of the State University of New York, office counseling techniques of physicians, and models of sex therapy provide a background for the sex educator in counseling. A Reality Therapy model of counseling is developed for the use of the educator in treating immediate causes of sexual dysfunction.

CHAPTER 1

THE CONTEXT OF COITAL BEHAVIOR AMONG SINGLE ADOLESCENTS AND YOUTH

Incidence of Coitus Among Single Adolescents and Youth

A comprehensive summary of the sexual behavior of individuals has been conducted by Morton Hunt (1974, 1973) under the aegis of the Playboy Foundation. Using a sample of 2026 persons in 24 cities and suburban areas, the Research Guild, Inc. administered four forms of questionnaires to male and female, married and unmarried individuals. The questionnaires elicited responses from individuals related to their sexual attitudes and practices. The information obtained was very similar to the information sought by Kinsey a generation ago (and in some areas the information was much more complete as in anal erotic experiences, sadomasochism, mate-swapping and group sex, and incest). In his report Hunt compared the findings of his study with those of the Kinsey reports. However, Hunt did not claim to use the same devices to obtain information nor did he test the significance of the differences in the percentages found by himself and Kinsey.

In his study of premarital sexual behavior Hunt claimed that there are "sweeping changes in the traditional attitudes of Americans toward premarital coitus and in the sexual behavior of the unmarried young." Kinsey had found that six out of ten college-educated men objected to premarital intercourse on moral

grounds while four out of ten men without a college education objected on the same basis. Within Hunt's sample 95 percent of the males and 81 percent of the females in the 18-24 year old age group reported themselves as having had premarital coitus. Among this same age group of men, 80 percent felt that premarital coitus was all right for men and 80 percent felt it was all right for women. Among this age group of women six out of ten felt that coitus was all right for females if there was strong affection and nine out of ten felt that it was all right for women if there was a love relationship. A smaller percentage of males and females in the total sample indicated that sexual intercourse without affection was acceptable. Hunt suggested that even though adults did not prefer sex without affection, they were more tolerant of it than they previously had been.

The Hunt survey indicated that petting behavior among the young had become more commonplace and yet less important than it had been in Kinsey's time. Petting behavior was a brief prelude to sexual intercourse among the unmarried young.

Casual coitus did not seem to be prevalent among young adults. Increases in casual coitus were reported to occur among men 25 years of age and older. Although more young women were engaging in coitus, they were likely to do so with men whom they loved and hoped to marry as was true of young women in the Kinsey samples. Among the males those men 35 years of age and over had had far more experience with prostitutes than did males 35 years of age and younger. Thus, the "permissiveness with affection"

standard that Reiss had described was supported by the Hunt data.

The increase of coitus among single young people was not without its incumbent problems and satisfactions. Many young people reported that peer group pressure pushed them into coitus before they were ready for it. Only four out of ten young males and two out of ten young females reported their first experience with coitus as "very pleasurable." Approximately one third of all males and two thirds of young females reported experiencing regret and worry after the first sexual intercourse and in some instances after several coital experiences. Fears related to pregnancy and venereal disease were also present while some individuals were troubled by emotional and moral conflicts. On the other hand, young people were experimenting with a greater variety of coital positions than they had at the time of the Kinsey reports and the actual duration of the coital experience was likely to have been longer than it had been at that time. (Kinsey did not collect this data for unmarried individuals, only for married people in which orgasm was occurring after two minutes of coitus.) The frequency of intercourse among single people was substantially increased in the last generation. Males' frequency of intercourse has increased from a median of 23 to 33 experiences per year during the generation. Only half of the unmarried females in the Kinsey sample experienced orgasm during coitus while three-quarters of the females in the Hunt sample experienced orgasm during coitus. The frequency of orgasm among women was considerably greater than the Kinsey sample. Many

young people reported that their peak sexual experiences occurred with individuals with whom they have loving relationships.

Bell (1970) conducted research for the purpose of determining whether or not there was a change in the premarital behavior of coeds. His previous research (completed in 1968) indicated that no striking changes in premarital behavior of coeds had occurred since the 1920's. Hunt (1973, 1974) also indicated that the most remarkable changes in the coital behavior of single females had occurred in the previous fifteen years. Increased sexual candor at the societal level as well as an increased use of the oral contraceptive tended to support predictions of increased sexual permissiveness among college students. Using matched samples this researcher duplicated a study conducted in 1958 on the campus of a large urban university.

Results of the study indicated that "the commitment of engagement has become a less important condition for many coeds engaging in premarital coitus as well as whether or not they will have guilt feelings about the experience." Bell stated that if this data is exemplary of patterns that exist elsewhere, this is the first significant change in premarital sexual behavior since the 1920's.

A survey was also conducted at the University of Colorado in the spring of 1967 by Kaats and Davis (1970) in which pre-1962 data on sexual behavior of college students was compared with data related to contemporary behavior. In 1967 premarital coital behavior of females had reached a level of 40 percent which was

approximately twice as high as it had been reported in other universities prior to 1962. The figure for males was 60 percent which was quite similar to the data reported before 1962.

Although there had been a marked change in the premarital sexual behavior of females, remnants of the double standard were clearly extant. Approximately half of the males adhered to a norm which allowed greater sexual freedom for the male. Females, too, reported themselves as adhering to a norm which permitted greater sexual freedom for the male. Males believed that their families and members of the society at large would disapprove slightly or moderately of having intercourse (regardless of the degree of affection) and that close friends would approve of the behavior. Women on the other hand, felt that all such groups would more strongly disapprove of their having premarital sexual intercourse. It was also found in this study that physically attractive women had a significantly higher frequency of premarital intercourse than did less attractive women although the attitudes of physically attractive women did not differ significantly from those of the total group.

The Physiological Revolution

Increases in teenage illegitimacy may have suggested an increase in premarital sexual intercourse among adolescents. The Commission on Population Growth and the American Future (1972) reported that out-of-wedlock births among adolescents 15 to 19 years of age were increasing. The comparative figures related

to illegitimacy were as follows:

Year	Number of Out-of-Wedlock Births
1965	125,000
1968	160,000
1970	180,000 (estimated)

Cutright (1972) conducted a study in which the preceding phenomenon was explained. It was reported that the age of menarche dropped by two years from 16.5 to 14.5 in the intervening years from 1870 to 1930. In the period of time between 1950 and 1970 the age of menarche dropped from 13.5 years to a predicted mean age of 11.5 years. Improved nutrition and health among preadolescent girls have been acknowledged as the major factors contributing to the lowered age of menarche. It was also hypothesized that the mean period of teen-age sterility which possibly has declined from 3 to 2.5 years is related to the decline in the age of menarche. However, this had not been substantiated. Thus, the age at which girls are fully fecund is decreasing and without any increase in the amount of premarital coitus, this phenomenon could account for a significant increase in illegitimacy rates of girls between 15 and 17 years of age.

Improved health also accounted for a decrease in the rates of fetal loss among unwed adolescent girls, particularly young, nonwhite girls.

It was unlikely that contraceptive practices among teenagers changed during the 1940's, 50's, or 60's inasmuch as contraceptive effectiveness among married people did not improve during the same period. Evidence also suggested that use of the

oral contraceptive among teenagers was low. In short, there was no evidence to suggest that teenage girls were better protected against pregnancy in the 1960's than they were in 1940. Neither was there much evidence to suggest that abortion increased from 1940 to the 1960's.

The increase in illegitimacy rates among girls who did not expect to marry their sexual partners was less than one-half of one percent. The increase in illegitimacy rates among girls who expected to marry their partners was 11.5 percent. Thus, a phenomenon that had been termed, "sexual revolution," occurred primarily among white adolescent girls who were involved in premarital sexual intercourse with partners whom they planned to marry. Changes in health or a "physiological revolution" accounted for many of the other ostensible signs of increased permissiveness.

Cohabitation of College Students

Macklin (1972) conducted a study related to heterosexual cohabitation among unmarried university students. Despite serious limitations (fifteen females constituted the sample) results were interesting. When asked what the nature of the relationship had been before cohabitating, (living together at least four nights per week) the modal response was, "strong affectionate relationship; not dating others." When asked what kind of a relationship should exist before college aged students cohabit the modal response was "strong, affectionate relationship; not

dating others."

Among cohabiting individuals the major emotional problem was a tendency to become overinvolved and to feel a loss of personal identity and to not participate in other activities or to be with other friends. Only a few cohabiting individuals indicated that they were having no sexual problems. Sexual problems included the following: differing degrees and periods of sexual interest, lack of orgasm, fear of pregnancy, vaginal irritations, sexual inhibitions and less sexual satisfaction as the relationship deteriorated. Three quarters of the participants rated the sexual relationships as sexually satisfying despite the problems. Practically all the cohabiting individuals were using some form of birth control and two-thirds had started using contraception before cohabitive coitus began. Another major problem of cohabiting college students was fear of parental reactions to cohabitation.

Norms and Sexual Behavior

A study of changing sex norms in America and Scandinavia was conducted by Christensen and Gregg (1970). Both in 1958 and in 1968 these researchers selected three samples of college students in each of the following three regions: a highly restrictive Mormon culture in the Intermountain region of the western United States, a moderately restrictive Midwestern culture in the central United States and a highly permissive Danish culture in Scandinavia. In both decades data regarding attitudes

toward sex and self-reports of coital activity were gathered.

Attitudes toward premarital coital activity in all three cultures were found to be more liberal in 1968 than in 1958. This was especially true among females. Differences in premarital coital activity between 1958 and 1968 were not as extreme as differences in attitudes toward premarital coital activity. Among males in the two American samples the incidence of premarital coitus was approximately the same in 1968 as it had been in 1958. (The authors predict that the slight increase that was present was actually nothing more than random variation.) Among females in the American samples precoital experience rose sharply. In the Danish sample the increase in premarital coitus rose sharply for both males and females. (The incidence of premarital coital activity in the 1968 American samples was fixed as follows: Intermountain males, 37%; Intermountain females, 32%; Midwestern males, 50%; Midwestern females, 34%).

Negative accompaniments of coitus were also studied by the researchers. Incidence of coitus because of pressure by partner was more fequent in restrictive cultures than in permissive cultures, more frequent among female than males, and more frequent in 1958 than in 1968. Furthermore, the incidence of coitus followed by guilt or remorse was generally higher in the restrictive cultures than in the permissive cultures, generally higher for females than for males, and consistently higher in 1958 than in 1968.

The rapid changes in attitudes relative to slower changes

changes in behaviors suggested that there was a decline in behaviors that were discrepant with values. Christensen and Gregg asserted that "values and norms serve as intervening variables affecting the effects of behavior." They also stated that "value-behavior discrepancy is associated with sexual restrictiveness; and certain negative effects of premarital intimacy are associated with sexual restrictiveness." It was thus suggested by the authors that the value-behavior discrepancy was the source of negative accompaniments of coitus.

The results of research conducted by Perlman (1974) are similar to those of Christensen and Gregg. Perlman reviewed Stratton and Spitzer's viewpoint thesis of social deviance in explaining the relationship between self-esteem and sexual permissiveness:

> They assumed that within any given society there are cultural norms prescribing appropriate sexual behavior. These norms are internalized by members of the society (or subculture). People who conform to the norms tend to evaluate themselves positively, but people who deviate tend to evaluate themselves negatively. (Perlman, 1974, p. 470).

Implicit in this viewpoint is the notion that the permissiveness/self-esteem relationship is dependent upon cultural norms.

An all-female sample of students at a sexually moderate midwestern Canadian university and a male-female sample of students at a sexually liberal New York college (with obvious limitations) were selected for the study. Using the Reiss Sexual Permissiveness items, comparisons were made between 1959 and 1973 groups.

In the intervening years male and female students on the New York campus were increasingly permissive of petting without affection among males and females. Acceptance of this was indicated by approximately 75 percent of the respondents. (However, acceptance was to an item of a general, unqualified nature rather than for oneself, one's sister or one's brother, or one's close friend.) There was a marked increase in acceptance of coitus when engaged, in love, strongly affectionate, and not particularly affectionate. The author stated that approval of coitus among couples without affection was strong enough to reject the "permissiveness with affection" standard established by Reiss.

In the moderate Canadian sample correlations indicated that highly permissive students were low in self-esteem. (The correlation was slight and non-significant as expected in a Moderate Culture). However, in the liberal New York campus culture high self-esteem individuals reported themselves as having had more coital partners than low self-esteem individuals. The results lent support to the theory that people who adhere to cultural norms view themselves positively.

Theories Explaining Sexual Intercourse among Single Young People

Several theories have been advanced which sexual intercourse among young unmarried people. Dominant among these theories is that of Reiss (1965, 1964). Using a samples of 903 student and 1515 adults the researcher tested the relationship

between socioeconomic status and premarital sexual permissiveness. Examination of the data extracted from both samples indicated that permissiveness was no greater among lower SES individuals than among higher SES individuals. Using high and low church attendance as indices of liberalism and conservatism respectfully, the hypothesis was retested. It was found that among conservatives (those attending church frequently) premarital sexual permissiveness declined with an increase in SES. Among liberals (those attending church infrequently) premarital permissiveness increased with an increase in SES. Reiss stated that these findings are congruent with his earlier theoretical position, "that the lower the traditional level of sexual permissiveness in a group, the greater the likelihood that social factors will alter individual levels of sexual permissiveness." The Kinsey data had previously established that lower classes were more sexually permissive than the upper classes. Thus, previously established low level of sexual permissiveness in the upper classes is more subject to the influence of social forces.

The Reiss hypothesis was subsequently retested by other researchers. Middendorp (1970) challenged the Reiss hypothesis stating that strong determinants of permissiveness in sexual relationships appear to be religion and age while weak determinants are residence and sex. Another study conducted by Vener, Steward, and Hagar (1972) among American and British adolescents supported the Reiss hypothesis.

Maranell et al(1970) conducted a study that was a subsequent

test of the Reiss hypothesis. A group of students was used as subjects. Measures of fundamentalism, idealism, academic orientation, and authoritarianism were used independently to identify liberals and conservatives. Several statistical tests failed to confirm the original Reiss hypothesis. Instead, the sex of the person was found to be a more valid predictor of permissiveness, males being more permissive than females.

Teevan (1972) explained premarital sexual behavior in terms of reference group theory. As a result of having the status of neither a child nor an adult, the adolescent achieved a sense of identity through his peers. Association with the peer group provided security to the youthful individuals and allowed greater independence and adult behavior than do parents. Teevan suggested that at the college level conformity to peer group expectations provided a transitional link between dependence on parents and adulthood. He further suggested that indulgence in sexual behaviors may be a means of rejecting parents while concommitantly gaining approval of peers. Within this context three hypotheses were tested using a stratified sample of 1177 college students attending twelve randomly selected accredited institutions in the United States.

A weak but statistically significant relationship was found supporting the hypothesis that college students who were more estranged from their parents were more likely to engage in premarital intercourse than those who reported a closer attachment to their parents. Among students who were less parent-

oriented, there was also a greater probability of having premarital coitus in the future. Support was also generated for the hypothesis suggesting that the perceived sexual behavior of friends and peers will have a marked, positive effect on the college-aged person's tendency to have premarital coitus. (Collins [1973] found that among 17-19 year old students sexual involvement was greater as interpersonal relationships become more serious and that among students pressure existed to conform to what students thought was the norm rather than to what actually was the norm.) The interaction of the two previously mentioned variables was in the expected direction. Incidence of coitus was high among students who were not parent-oriented and whose peers were viewed as being sexually permissive. The incidence of coitus was low among students who were parent-oriented and whose peers were viewed as not being sexually permissive.

Among sociologists there has been controversy regarding the relationship of attitudes to behavior. Three major perspectives have been suggested for explaining this relationship. The first indicated that attitudes are antecedents of behavior. The second indicated that attitudes and behaviors operate independently of each other, primarily because attitudes are so difficult to measure. The third suggested that attitudes and behaviors are meditated by contingent conditions. Using this third model as a basis, Clayton (1972) conducted a study in

which premarital sexual intercourse was the behavior that was influenced by attitudes and mediating contingent factors.

A sample was selected that consisted of 287 males and 369 females who attended a private university in Florida in 1970. Religiosity (as measured by Guttman-type scales developed by Faulkner and DeJong) was the general attitude. Two substantive contingent factors (as measured by modified Reiss items) consisted of the following: assessments of the norms of sexual permissiveness operative on the campus at large and assessments of the norms of sexual permissiveness operative within the group designated as most important to the individual.

Data indicated that all indices of religiosity were significant for males while four out of six indices were significant for females. All indices of personal permissiveness were significant for males and females. Perceived assessments of the norms of sexual permissiveness operative on the campus had little effect on the sexual behavior of either males or females; however, a trend in the data suggested that these asssessments may have been more influential on the behavior of males. Assessments of personal reference group norms of permissiveness were significant for males but insignficant for females.

Clayton offered several explanations for the latter phenomenon: greater orientation of males toward sex, greater desires of males for sexual conquests, greater cohesiveness of males as a result of living in fraternity houses rather than in dormitories, and a high desire among females to elicit public

commitment from the male.

There was very little interaction among the variables studied. Thus, support was generated for the notion that the variables were additive in their effect.

Anxiety Associated with Sexual Behavior

Langston (1973) in a study conducted among 76 male and 116 female undergraduate college students investigated the relationship between sex guilt and sex behavior. The Mosher Forced Choice Sex Guilt Scale and the Bentler Heterosexual Behavior Assessment Scale were administered to subjects. Subgroups of high and low female and male Sex Behavior Scale and Sex Guilt Scale as well as movie rating preference and number of obscene/pornographic books read were formed.

In this study it was found that sex guilt and sex behavior were inversely related to each other. Sex guilt was positively related to religious activity. Sex behavior and religious activity were negatively related. Sexual involvement for both males and females was the same but females experienced more guilt accompanying the sex behavior. Furthermore, females with high sex guilt and low sex behavior preferred nonerotic films and literature. This relationship was not established for males, however.

In another study with 138 women enrolled in an introductory psychology class Joesting and Joesting (1974) administered the Taylor Manifest Anxiety Scale, Schaefer's Biographical Inventory

Creativity, What Kind of a Person Are You, Equalitarianism (Forms A and B) and four scales developed by the authors themselves. These scales included the following: Women's Views of Contraception, Sex-Role Questionnaire, Can Do and Should Do. (These last two measures were related to women's occupations). Correlations among Women's Views of Contraception and Measures of equalitarianism and creativity were significant at the .01 level. Low correlation between the Manifest Anxiety Scale and the What Kind of Person Are You indicated that those women held modern views on contraception, sex, and equalitarianism of females. The authors concluded that women with equalitarian views were significantly more anxious than women with opposing views. This supports previous research done by Bardwick who found that changing values of women are causing women to be more anxious. This was particularly significant among those women who were seeking life styles that have not been held traditionally.

Contraceptive Behavior Among Coitally Active Adolescents and Youth

Goldsmith et al (1972) conducted a study among sexually active unwed girls aged 13-17. Over 50 percent of the girls interviewed were never pregnant and were seeking contraceptive help; 25 percent were seeking abortion; and 20 percent were in homes for unwed mothers awaiting the births of their babies. The contraceptors showed more initiative in seeking birth control than did the other two groups who sought help only after pregnancy occurred. It was suggested that this group was more acceptant

of their own sexuality. (This was an inference made on the basis of a response to one item on a self-reporting device of unknown validity. Nonetheless, the idea is supported by Pohlman, [1946, p. 355] who stated, "Individuals and couples willing to accept sexuality probably are able to contracept more effectively because they can think and talk about it more freely and perhaps practice it less clumsily.")

It was suggested that the sex education programs in which these girls previously had been involved taught the mechanics of reproduction and birth but had failed to deal with masturbation and orgasm. Nor were they told where they could go for contraceptive services. This might have been the most important component of an effective sex education program.

Contraceptive behaviors of college students were studied by Bender (1973). The researcher acknowledged the work of Reiss which indicated that there was a significant change in the premarital sexual behavior of females increasing from 50 percent in the 1920's to 70 percent in the late 1960's. Such data indicated existence of an era of changing sexual mores and might even have suggested that increased sexual responsibility accompanied this change. However, the incidences of illegitimacy, venereal disease, and sex-related divorce clearly did not support this notion. (Oswalt, 1974; Hall, 1974; Garner et al 1974; Fieman, 1974; Evrard, 1974.)

Bender's research revealed that a greater percentage (84) of females might engage in premarital intercourse but they them-

selves would not have started taking the oral contraceptive until after they had found someone with whom they wished to have intercourse. Nor, did they expect their dates to carry a condom. The female subjects believed that both parties were responsible for birth control but did not expect either to be "prepared" ahead of time. Responses of males were quite similar to those of the females.

Both sexes indicated that they wished their first coital experience to be spontaneous and indicated that they proceeded having coitus interruptus or intercourse without contraception, "hoping for the best." This lack of rational decision-making was attributed in part to a double standard which suggested that a female should "succumb to her lover."

Schwartz (1973) in a well controlled study among 28 male and 28 female college students investigated the relationship between sex guilt, sexual arousal and the ability to retain sex information. Subjects were selected from a much larger group of students (180) on the basis of scores attained on the Mosher Forced Choice Guilt Scale. Half of the high guilt group and half of the low guilt group were assigned to subgroups in which reading erotic and neutral literature occurred. Then, all subjects were exposed to a lecture on a little-known topic related to birth control. A quiz on the lecture followed exposure. High guilt subjects retained less lecture information than did low guilt subjects. Sexually stimulated individuals retained less information than did non-stimulated individuals. Females retained more sex information than did males.

Summary

A brief review of the literature related to sexual behavior among unmarried young people revealed that coitus among these young people definitely had increased. This trend was most apparent among females and individuals eighteen years of age and over. Examination of attitudes revealed that double standards of various sorts existed but not to the extent that they did in the 1920's. Sexual behavior was influenced by values and norms, religious beliefs, degree of conservativism or liberalism, peer group pressure, relationship with parents, physical attractiveness, as well as the degree of affection. Among many young people premarital intercourse did not appear to be preceeded by a decision-making process which included preparations for birth control. Thus, fear of pregnancy or pregnancy itself was one of the major problems associated with coitus among the unmarried. Several other problems were associated with coitus among the unmarried young people although there were many satisfactions related to their experiences with sexual intercourse.

CHAPTER 2

SEX COUNSELING OF THE PSYCHOLOGICAL SERVICES, STATE UNIVERSITY OF NEW YORK

Background

Bauer and Stein (1973) of the Psychological Services, State University of New York, indicated that within a two and a half year period over 800 students approached them with problems of a sexual nature. Believing that an essential developmental task of youth is achievement of the capacity for lasting relationships as well as for tender and genital sexual love in heterosexual relationships, these counselors developed short-term treatment techniques for sex counsling on campus. A major objective of such treatment was dealing with sexual problems at a critical time before sexual dysfunction occurred.

Counseling Procedures

Inasmuch as student couples (most often unmarried) arrived at the counselor's office somewhat embarrassed, these counselors deviated from standard procedures of taking a sexual history. In taking the sexual history these counselors attempted to maintain a delicate balance between taking too much information and taking too little information. Rather than using an open-ended client centered style (such as the one suggested in the 1973 publication of the Group for the Advancement of Psychiatry), Bauer and Stein

asked specific questions in a somewhat authoritative manner. The purpose of this approach was twofold: first, it inspired confidence of the clients in the counselor "experts" and second, it served as a model of open communication regarding sex.

Bauer and Stein suggested that there are four therapeutic and diagnostic procedures that they employed. First, was a discussion of birth control. They found that requests for birth control information were generally coupled with other anxieties regarding sexual behavior. Thus, they did not give birth control information without discussion other aspects of the couple's sex behavior. Interestingly, this discussion often revealed areas of tension between the couple.

A second diagnostic and therapeutic technique used by this team was bibliotherapy. College students were often amazingly ignorant in their knowledge of sexual functioning. These counselors contended "...that the same embarrassment and unconscious resistance to being overtly sexual, which partly underlie their dysfunction in the first place, also account for their hesitancy about seeking out reading materials in bookstores or libraries (Bauer and Stein, 1973, p. 829)." Counselor suggestion of reading provided students with permission and motivation which previously had not existed. This was followed by a discussion of the materials in which students are encouraged to ask any questions that they might have. (Marcotte [1974], McCarthy et al, [1975], also warned that the use of reference material should not be the primary therapy; counseling is necessary to alleviate anxieties

to which patients may build defenses.) Bauter and Stein (1963, p. 829) warned, "We avoid bibliotherapy with obsessive clients who are hoping that their problem is a disorder of technique rather than of feeling because reading tends to exacerbate their mechanical approach to sex." (McCary [1971] noted that among therapists bibliotherapy has been well acknowledged as a means of facilitating changes in attitudes, emotions, and behaviors even though scientific data establishing the validity of the process had not been gathered.)

Setting-the scene is a third procedure of therapy and diagnosis used by these counselors. Many college students regarded sex as a natural function. Accordingly, and mistakenly, they also regarded "stage setting" as a "corruption of naturalness." Consequently, feelings of anxiety arose when sex was not pleasurable in unembellished surroundings (such as the dormitory room with a sleeping rommate present). When it was suggested that a variety of sexual techniques, use of fantasy and enhancement of the setting could improve sex life, this knowledge proved relief for sexual partners who believed themselves inadequate because sex had not been pleasurable.

Referral to a physical was a fourth diagnostic-therapeutic technique used by these counselors. Males with any of the following difficulties were referred to a urologist: failure to ever have an erection, painful erection or ejaculation, doubt related to size or intactness of genitals, situational impotency, premature ejaculation, inability to ejaculate intravaginally, or

or evidence of a lingering hope that some physical difficulty may have accounted for the dysfunction. Females with any one of these difficulties were also referred to a physician: painful intercourse, pain with genital manipulation, doubt regarding intactness or functioning of the sexual organs, problems associated with menstruation, vaginal infections, contraception, and anxiety associated with lack of orgasm. Both males and females were prepared for the procedures involved in the medical examination as well as for the fact that the physician possibly would not take the sexual problem of a young person seriously. The students were encouraged to write down their questions prior to the time of the physical examination and then to pursue in seeking answers to the questions from the physician.

Bauer and Stein categorized sexual problems of students into four distinct categories. The first of these categories was misinformation or situational stress. Sexual problems of approximately half of the students were of this nature. The problems were related to a lack of information or to an ambience unconducive to effective sexual functioning.

The second category was the child-parent relationship. In some instances parents were quite dependent on their children and had attempted to keep their children "as children." Sex, then, to those individuals had become an area where they attempted to demonstrate their independence. When these were the motives underlying sexual intercourse, Bauer and Stein suggested that the couple cease from having coitus until autonomy from parents

had been attained.

The third category of sexual disturbance was in the couple's relationship. In these instances sexual problems were a reflection of stress in the interpersonal relationship of the couple. Sometimes the couple was engaging in intimacies which were not commensurate with the amount of affection that they held for one another. Other times the young man and woman really did not care for one another at all and sexual intercourse was either a thrill-seeking experience or one whose purpose was a search for security. In these instances couples were often "looking for a way out" and welcomed the opportunity to end the relationship. In other instances one member of the dyad complained of having outgrown the other. This member becomes restive and the other became manipulative. The counselor in this situation enabled the couple to recognize the "games" that they were playing.

The final category of problem was that of psychiatric disturbance. Students with problems of this sort often had histories of emotional deprivation and trauma since childhood. Often there had been disturbances among the parents of these students. Delusions and even hallucinations were reported and interpersonal relationships were unstable among these individuals. Long-term psychotherapy was required for alleviation of these problems. This was communicated to the students at the onset. However, short-term counseling related to sexual problems was offered for the purpose of reassuring, clarifying misinformation

and redirecting energies toward different goals where possible.

Specific Problems

A common complaint of female students was dyspareunia. At the onset young women were counseled to cease having intercourse so that pain would not become associated with coitus. Physical examinations were routinely performed. Questioning often revealed that the woman was harboring a wealth of misinformation, often related to the amount of pain associated with initial intercourse. Young women frequently had received faulty impressions from the medical team attendant during a pelvic examination. Fearful fantasies about male and female sex organs were often present among many young women.

Specific educational techniques included the correction of misinformation through the use of models. Women were instructed to explore their vaginas with their fingers. And, finally they were taught how to voluntarily constrict and release the vaginal muscles to achieve control and increase sexual pleasure.

Women often sought counseling for what they termed, "frigidity." Even when intercourse had occurred only a few times, women felt inadequate if orgasm had not occurred. Many times young women had not masturbated and knew neither what pleasured them nor what the sensation of orgasm was like. Expectedly, many young women felt that it was unbecoming to communicate to partners those things that were sexually pleasing

or displeasing. Women were generally unassertive. The involved males felt inadequate because they were unable to "give an orgasm" to their partners. Thus, a vicious cycle was created.

In counseling with women who experienced orgasmic dysfunction counselors generally suggested experimentation with the body and stimulation of sensual feelings. Couples who were enjoying sex were encouraged to relax and wait for orgasms to occur in the lovemaking process. Couples were encouraged to be communicative regarding their sexual needs and desires. The myth of "giving an orgasm" was clarified, particularly when men indicated that their masculine self-images were dependent upon this.

Premature ejaculation and impotence were problems that frequently beset young men. The first step suggested by Bauer and Stein was "pinpointing" those experiences that caused the young man to come to the office. Often premature ejaculation and impotence among were the results of situational factors or unrealistic expectations. In such instances reassurance restored self-confidence in the male.

Also manifest were more serious causes of these dysfunctions. Males suffered from fearful fantasies. Education through the use of models, pictures, and digital exploration of the partner's vagina (with her permission) was used to overcome these fears. Males ejaculated prematurely when they were frightened by fantasies of a fully aroused woman. Discussion of these fears and fantasies generally marked a period of changed

behavior in males.

When premature ejaculation and situational impotence occurred with a committed couple whose relationship was of some duration, modified versions of the techniques developed by Masters and Johnson were used in treatment. Such techniques included the following: cessation of coitus, sensate focusing and development of awareness of ejaculatory inevitability. Males were encouraged to masturbate, increasing the length of time prior to ejaculation with succeeding attempts.

Another problem occasionally encountered by college-aged men was fear of homosexuality. Males with either little experience with females or unpleasant experiences with females sometimes identified themselves as homosexuals. Such men were usually celibate rather than homosexual. Confronting the individual with the lack of evidence suggesting that he was homosexual and focusing upon the reasons for celibacy were office counseling techniques employed. In addition group therapy was often found to be affective for such men.

Bauer and Stein remarked that confirmed homosexual males and females rarely asked for counseling service. Request came from heterosexual males (described above) who were experiencing anxieties, from males who wished to change their homosexual orientation, or from homosexuals that were learning to accept their homosexuality.

Promiscuous behavior occurred among males and females. Males generally reported sex as pleasurable; females sometimes

reported sex as pleasurable. Fear of closeness or commitment seemed related to promiscuity. Counseling sessions focused upon this fear and its origin in the family life of the individual.

Approximately twelve rape victims yearly sought counseling help. The rapes encountered were often a result of carelessness (hitch-hiking) and lack of assertiveness (not getting out of the car) on the part of the female. Anxieties, fear of sex, fear of men, nightmares and guilt were feelings commonly experienced by rape victims. Often the rape victims had not vented their anger. Counseling sessions focused on assuring the woman that she was not permanently damaged. Counselors also provided models for the ventilation of anger by the counselee. In instances where the rape was provoked by the woman herself psychotherapy was recommended.

Unwanted pregnancy occurred approximately 150 times in two and a half years. Counseling techniques focused on exploration of all the alternatives possible to the pregnant young woman. In all instances clients chose abortion as the most suitable alternative. Generally, the experience of having an abortion resulted in greater responsibility on the part of the counselee. Women who had several "unwanted" pregnancies were referred for psychotherapy.

Summary

The authors stated that general therapeutic approaches were used in counseling with students. These included the

following four procedures: (1) use of counselors as models, (2) collection of information related to history, fantasy, sexual expectations and birth control practices, (3) referral to physicians, and (4) bibliotherapy. The second phase consisted of categorizing behaviors into one of four problem categories: (1) misinformation, (2) child-parent relationships, or (3) couple's relationship. Finally, the third major phase of sex counseling dealt with the use of therapeutic decisions and tactics for alleviating the following specific problems: pain with intercourse, premature ejaculation, impotence, homosexuality, promiscuity, rape, and unwanted pregnancy.

CHAPTER 3

OFFICE COUNSELLING TECHNIQUES

Communication Related to Sex and Sexuality

The stimuli that have bombarded individuals have had a profound effect on the self-esteem and sexual expectations of many. The pressure for sexual activity in the society is so great that many people felt compelled to act sexually before they have made a conscious decision to do so. (Menninger, 1974). Pressures upon young men are especially great as indicated by the fact that male virgins frequently report themselves as unhappy about the situation (Arnstein, 1974). Pretense of knowing "everything about sex" had typically been part of the masculine image and self-concept in this country. Thus, as a result of various forces the male has been unduly sterotyped if not potentially crippled in his sexual relationships (Clark, 1975).

Likewise females have been victimized by the bombardment of sexual imagery that has been present in the society as well as by the myth that a truly masculine man is omniscient in things sexual. Thus, some females have not taken any responsibility for communicating their own sexuality or for communicating to their sexual partners those things which were pleasing and those things which were not. (Vincent, 1975). Furthermore, much of the sex-related literature of the recent past has been related to females; as a consequence females have developed high expectations for sex.

When sex has not measured up to these expectations, disillusionment ensued. On the other hand much of the popular culture has suggested that sex is "natural." Prohibitions related to sex have often been referred to as "hangups" and in this sense sex has been highly underrated (Kephart, 1974).

Thus, individuals or couples who present themselves for counseling or therapy come to the counseling sessions with a vast barage of sociopsychological factors which have influenced their sexual functioning.

Sexual History Taking

Having established a rapport with the counselee and ascertained the nature of the circumstances surrounding the problem situation, the physician or counselor takes a sexual history of the individual and/or the couple. Interviewer calmness and as well as acceptant responding to the clients' statements were two important variables in determining the effectiveness of taking a sexual history. Use of mutual language and defining terms were cited as important in facilitating communication between client and counselee. Proceeding in chronological order as well as proceeding from topics that produce less anxiety to those that produce higher anxiety were techniques for gaining maximum information from the client. Insuring the counselee of confidentiality was cited as very important in effective interviewing (Committee on Medical Education, 1973; Schwartz, 1974).

In taking a sexual history of a college student

consideration of the developmental tasks of youth was important. The first task was resolution of the child-parent relationship. Sexual behaviors might have occurred to spite parents. This was manifest in promiscuity and in the selection of partners whom the parents disapproved. A second developmental task was solidifying sexual identity. Parents as role models may have been inadequate. This was known to cause concerns related to homosexuality. Formation of a personal value system was a third task. On the college campus personal values (including sexual values) were always challenged. Therefore students had to select values that were personally suitable. The fourth task was the development of a capacity for intimacy. An individual who did not have intimate relationships sometimes used sex as a mean to intimacy and thereby became more lonely after unrewarding sex. Through discussion of these tasks, physician-patient rapport was established (Coons, 1974).

Gadpaille (1974) discussed counseling with the young adult with sexual fears. He indicated that young people were increasingly having sexual intercourse outside of marriage but that the cultural and religious morality were for the most part restrictive. Thus, behaviors deviated from norms. He suggested exploring with the client the religious and group standards that were important to him. Then, it was suggested that the circumstances in which fear is aroused be explored. Fears common to young men were those associated with penis size, habits of masturbation and possibility of hurting a female partner and performing. Fears

common to the female were those associated with menstruation, pregnancy, coital pain, and sexual "use" by a man. One fear of females that required psychotherapy with that of violent mutilation from penile penetration.

Treatment of Orgasmic Dysfunction

Olsen (1974) described the characteristics of couples where the wife was "frigid." Both partners often lacked significant information about anatomy, physiology and techniques of sexual arousal. There was a general reluctance to discuss sex which may in itself have accounted for the difficulties of the partners involved. There were also withdrawals of a physical or psychological nature. Husbands were significantly involved in the problem. Husbands were often more tense than wives in regard to the sexual dysfunction. Thus, each person was responsible for the problem that had occurred.

Zussman and Zussman (1974) suggested that it was quite unlikely that a dysorgasmic female feels "nothing" and that it was necessary for a woman to communicate her sexual needs and to be sexually involved.

Within the counseling session Sadock (1974) described a routine for dealing with problems dealing with female dysfunction. One or more individuals may come to the counselor; if only one partner came it was requested that the other partner come. Having the couple meet the counselor served several objectives. First, it facilitated clarification of the problem and enabled the couple

to see that improvement of the man's techniques was a joint venture. Presuming that there was no specific deep-rooted difficulties (only faulty techniques) Dadock had the couple proceed with some simple exercises. Coitus was to cease and be replaced by carressing of the genitals. The female was encouraged to explore her body and to masturbate (it was mentioned elsewhere that females reach orgasm 95% of the time during masturbation. On the average this required one to three minutes of stimulation to the clitoral area. [Stanley, 1974]). At this point the counselor was alert for negative reactions from the males whose "masculine image" had depended upon his knowledge of sex and his ability to arouse the female. It was sometimes necessary to point out that masturbation was an effective beneficial means of teaching him what was satisfying to her. Mutual genital pleasuring also occurred, then, for two weeks before the couple was permitted to proceed to intercourse. Burchell (1975) also suggested the use of such techniques.

Thus effective treatment of female dysorgasmic function required that females learn to accept some responsibility for her own sexuality. It created in both individuals the capacity for being both active or passive at various times. Communication of sexual needs and educating one another through genital pleasuring were both integral parts of the treatment.

Peles, (1974) described the treatment of an extremely inhibited woman. He stated that this woman suffered from depression or even an arrest of her sexual function. The etiology

of inhibitions may have been physiological, psychological, or sociocultural. But little knowledge related to the physiology of love existed. Therefore, treatment was usually psychological in nature. It has been stated elsewhere that inhibitions and dysfunctions are almost always psychological in nature. (Masters and Johnson, 1969).

Several office counseling techniques were discussed. Development of a supportive, trusting, acceptant, and friendly atmosphere was required when discussing sex. A sex history was taken that discussed interpersonal relations, attitudes toward sex myths and misconceptions about sex, and previous sexual experiences were discussed. Presentation of biological facts about sex occurred. Providing relevant feedback of information to the patient aided in clarifying misinformation as well as in establishing reasonable goals for the counseling. The use of sensate focus exercised followed by open communication and eventually be the female-atop position of sexual intercourse was recommended. Discussion of masturbation was cited as an important component of the counseling procedure. Finally, the importance of the participation of a committed and loving man of paramount importance in overcoming inhibitions.

Perlmutter (1975) discussed organic bases for orgasmic dysfunction. When a client claimed not to be sexually responsive the alert counselor determined if drug use had occurred or if there were any health problems. It was also determined if there had been any pain associated with intercourse or if (in the case

of the middle-aged woman) menopause was occurring. Such clients were referred to a competent physician.

Vaginal Constriction, Dyspareunia

Vaginismus was described as an involuntary spasm of the vaginal muscles including pubococcygus. Dyspareunia was almost always related to the onset of vaginismus. In treating this condition a physician (Sexually Therapy Center of New York Medical Center, 1974) performed a physical examination in which the vaginismus was demonstrated to the couple. This was done because vaginismus was rather common and easy to cure once a couple understood it and wanted a cure. Sometimes prescription of a diaphragm was a component of the treatment process as it was believed that insertion of the diaphragm would be educational and that unconscious fear of pregnancy may have been a part of the problem. Previous attempt of intercourse during spastic contractions had caused the pain which had reinforced the fear which had reinforced the contractions. In order to break this "vicious cycle," treatment consisted of "teaching" through a deconditioning process that intercourse without pain was possible. Sensate focus exercises as well as manipulation of the genitalia were prescribed to the couple. Behavior modification techniques generally were used rather than the psychodynamic techniques of psychotherapy.

Promiscuity

Using the term, promiscuity, as meaning indiscriminate

mingling, Hofman (1974) discussed the problem. It was suggested that counting partners or coital experiences was a simple task while assessing other possible emotional psychological difficulties was much more complex. Serious difficulties with teenage sexuality often have occurred when there was unresolved sex-related guilt, or anxiety, when sex was exploitive, when it prevented normal development in other areas, or when it was associated with a serious breakdown in communication. Sex may have been used maladaptively by some adolescents. Motives for sexual behavior were evaluated by exploring with the individual his relationships with others and his satisfaction and progress in school. Duration of the problem and the amount of insight that the individual had were important factors for consideration by the counselor. Helping the individual resolve her own problem was cited as a major goal of counseling. Use of contraception was an immediate short range counseling goal (and one not easily implemented if the underlying motive itself was pregnancy.) Parental involvement in the counseling was deemed highly desirable.

Hofman delineated nine psycho-therapeutic steps suitable for use by a general practitioner. They were supportive in nature and designed to alter harmful situation responses. The first was ventilation of feelings by the patient. This was followed by gaining of insight by the counselee and the counselor through examination of how the patient functioned. Exploration of the various options, choices and decisions available to the client then followed. Facilitation of substitution of more healthy

alternatives in place of those that were less healthy was attempted by the counselor. Behavior modification procedures were initiated through reinforcement of the patient's positive and improved behaviors. Improvement of the youngster's communication with parents and schools was also attempted whenever possible.

Hoffman suggested that an individual with a high degree of insight may be counseled in an office setting. Suspicion of deep underlying emotional difficulties warranted a referral to a psychologist or a psychiatrist.

Impotence

Causes and treatments of impotence in the male were discussed by Labby (1974). Condition of a male who had had an erection under any circumstance was designated as secondary impotence. In cases of primary impotence (where erection never had occurred) a physical examination was necessary. The importance of taking a documented sex history and assessing crossover problems between mates was stressed. A significant part of the sexological interview was determining whether impotence was primarily related to sexual behavior or if it was a part of a larger syndrome of a life problem. It was emphasized that the onset of impotence created a vicious cycle in which fear negatively conditioned the behavior thus increasing the likelihood of its reoccurrence.

Treatment of psychogenic impotence consisted of cessation of intercourse and pleasuring of the nonerogenous zones of the body.

This was followed by a counseling session and pleasuring of both enerogenous and erogenous zones. Later, after several pleasuring sessions, the female was instructed in manipulating the penis to erection and then in the female atop position of intercourse to insert the penis into the vagina several times in a teasing fashion. Next, quiet vaginal containment of the penis occurred. Gentle female thrusting was permitted. Meanwhile, the male was encouraged to develop control of ejaculation by withdrawing and reinserting the penis. This exercise was designed to serve as a desensitizing experience whose purpose was elimination of performance anxiety. At that point most couples proceeded with intercourse and found it very satisfying. Couples were instructed to consult the physician if impotence reoccurred.

Studies by Roboch (1970) shed some interesting light on the condition of impotence. In one study the analysis of a group of 600 men revealed that approximately 66.6% of them became impotent after having had a successful period of sexual relations. The remaining 33.3% experienced difficulties related to impotence from the beginning of their heterosexual relationships.

A second study (Roboch, 1970) dealt with 2087 men who had experienced functional difficulties in their sexual relationships. Anxieties related to sexual inadequacy were most frequently reported in the subgroups of men approximately twenty years of age. Premature ejaculation occurred most frequently in men aged 26 to 30 years of age. Sexual frigidity was the most frequent complaint of patients between 46 and 50 years of age. The most

frequent sign of sexual failure was a disturbance of erectivity in approximately 50% of the cases, the incidence of this disturbance increased with age.

Kirkpatrick et al (1974) found several types of female behavior which related to impotence in the males. One such behavior was a high degree of fondling, kissing, and holding of the nongenital areas, often accompanied by evidence of disgust and disdain for male genitalia. Wives of impotent husbands often felt entitled to an extreme amount of sexual passivity. These women sometimes felt the same disgust with their own genitalia. Body responses of the females sometimes discouraged penetration. Female lack of interest and enjoyment was often "smokescreened" by concentration upon the husband's lack of sexual interest and ability. Finally, the wives of impotent men often interpreted the impotence as a personal rejection by their husbands.

Premature Ejaculation

Premature ejaculation was described as ejaculation by the male just prior to, at the time of, or too soon after penetration thus preventing his partner from having satisfaction during 50% or more of the episodes of sexual intercourse. Once this pattern was established it created a repetitive cycle of anxiety and fear of failure which caused "spectatoring" in the male. The initial interview was held with the man and his spouse. A sex history

and a physical examination were given to both partners. The physician also looked for hostility, incompatability, and psychopathic problems which would hinder the counseling process and warrant psychiatric intervention. A sexological examination followed the preliminary routines.

Then (over a period of two or three weeks) the partners were instructed in the sensate focus exercises, genital caressing and the squeeze technique. When the male was able to prolong his ejaculation intercourse was attempted with continued use of the squeeze technique. These exercises were done under the supervision of the physician and in combination with counseling and supportive therapy (Adelson, 1974).

Education as a Means of Improving Sexual Functioning

On the basis of having treated approximately one hundred couples with sexual problems in a period of three years, Caplan (1974) hypothesized that unrealistic expectations are at the roots of many sexual problems. Such expectations negatively influenced sexual performance and thus interfered with the general quality of the relationships of people involved. He stressed the importance of "giving to get" in a sexual relationship, which is the antithesis of the religious ethics of many people, yet of tremendous importance in a pleasurable sexual relationship.

Schmidt (1975) suggested that the use of the term, "foreplay" has established an external performance standard for many

coitally active partners. The word itself implied that something else is to follow, that of course, being intercourse and orgasm. Thus, sex may have been goal oriented for many individuals. Sexual competency may for some have become synonymous with good technique with a concommitant de-emphasis upon the likes and dislikes of the partner involved. Loveplay was suggested as a more appropriate word in that it insinuated that all of love-making could be very pleasurable.

Many people have had been repelled by the thought of using oral genital sex. Fink (1975) described his method of dealing with individuals who were experiencing such conflicts. He stated that there are four keys to dealing with the problem: exploration, reassurance, education, and supporting a patient's freedom to refrain. In the exploring phase of the problem solving experience, the counselor determined who was having the problem related to the use of oral genital sex and then help that person (or persons) to explore their beliefs related to cunnilingus and fellatio. Some people believed that it was a perversion associated with homosexuality or that it could have become favored over sexual intercourse. Still others believed that all sexual episodes should terminate with coitus; thus, this was not seen as a viable alternative to intercourse. Some felt that it was a duty or that it was degrading. Commonly held was the belief that cunnilingus and fellatio were dirty when in fact the bacteria count of the mouth has been found to be higher than that of the genitalia of a person who engages in routine procedures of cleanliness.

In dealing with the subject of oral-genital sex the counselor reassured the couple by developing a trusting relationship with the couples and by tacitly giving them permission to engage in the practice. The counselor educated the couple by assuring them that they were not the only ones who felt this way but that oral-genital sex was a healthy practice enjoyed by many. It was also necessary for the counselor to allow freedom of the individual(s) to choose not to participate in such practices. Furthermore, there was a possibility that prohibitions against the use of oral-genital sex may have been psychopathological in nature and not amenable to intervention with the use of office counseling techniques.

Experimentation of a variety of positions of sexual intercourse has been related to greater pleasure in lovemaking as well as to the onset of anxieties in the participants. When anxiety occurred in the participants, Burchell (1974) discussed with the clients the basic positions of sexual intercourse and the advantages and disadvantages of each of them as well as the feelings and associations that each member may have had related the coital positions.

Freedman (1975) discussed counseling techniques that were used with couples who had a stable relationship but in which the woman was able to reach orgasm only through manual stimulation. He stipulated that at the onset of the session the physician must discriminate between those couples whose relationship required therapy and those whose relations could be improved by education,

reassurance or counseling. Individuals who had several unresolved difficulties or whose sexual response was unconsciously inhibited were referred to a specialist. Problems which resulted from faulty technique or unrealistic expectations were handled in the office counseling setting.

Friedman recommended that the couple be seen jointly, then each individual was to be seen separately, and finally they were seen conjointly for a final consultation. In taking a medical history it was important to determine what had motivated the partners to seek help when they did. Discussion of this decision revealed information related to each partner's feeling for the other as well as their attitude toward their own sexuality. During these interactions the physician determined whether or not the condition was one which could be handled in the office counseling setting. If the relationship between the couple appeared to be sound, a sex history was taken and a physical examination recommended for one or both partners. If not, difficulties became apparent by this point and, if the couple appeared to be enjoying their sexual relationship, there was a strong possibility that they were victims of the fallacy that "vaginal orgasm was better than clitoral orgasm." In this case it was the role of the physician to educate and reassure the couple that their sexual life was normal. There was also the possibility that the act of sexual intercourse was eliciting fears, most likely of pregnancy. Still, some unconscious fears were severe enough to warrant referral to a psychiatrist.

Sexual intercourse is often misused by consenting adults. Racy (1974) indicated that the sexual impulse is so powerful and so malleable that it permeates all realms of human behavior. Sexual intercourse used for any one of the following purposes leads to sexual difficulties that are accompanied by suffering of the participants:

1. Sexual intercourse as a duty.
2. Sexual intercourse as a way of holding on to another.
3. Sexual intercourse to repay or secure a favor.
4. Sexual intercourse as proof of "loyalty."
5. Sexual intercourse to prove one's masculinity or power.
6. Sexual intercourse to prove one's maturity and sophistication.
7. Sexual intercourse as punishment of others.
8. Sexual intercourse as veiled suicide.
9. Sexual intercourse as a substitute for verbal communication.
10. Sexual intercourse as a way of obtaining warmth or bodily contact.

In these instances counseling was used in order to return sexual intercourse to its proper perspective as an activity which brought pleasure to both individuals.

Summary

Techniques for counseling patients with sexual problems and dysfunctions have been developed by physicians. The techniques were generally brief and in many instances superficial. All were developed with the assumption that the practitioner was trained in a variety of modes of intervention in problem situations as well as in normal and abnormal sexual response. Many problems of sexual dysfunction among couples whose relationships were sound stemmed from inadequate knowledge of sexuality,

ineffective techniques, and prohibitions against sexual behaviors. Most office counseling techniques were based upon principles of self-understanding and communication, responsibility for one's own sexuality, and the pleasuring of one's partner for the purposes of both giving and receiving pleasure.

CHAPTER 4

COUNSELING TECHNIQUES APPROPRIATE FOR THE COLLEGE LEVEL SEX EDUCATOR

Statement of the Problem

It has been clearly established that problems related to sexual dysfunction are prevalent in today's society (Masters and Johnson, 1969). Such problems have many origins. Some are related to misinformation and myths and may be treated through re-education. Other problems are relieved through superficial kinds of sex therapy in which behavior modification procedures are employed. Problems related to severe psychopathology require psychoanalysis and/or marital therapy for treatment (Kaplan, 1974).

Kaplan described the effects of early sexual failure upon sexual problems:

> Early sexual failure is often an important factor in the pathogenesis of sexual problems. The youngster who is just beginning to experiment with sex is particularly vulnerable to the negative contingencies which are produced by his emotional reaction to an unsuccessful sexual experience or by an unkind response from his partner. Moreover, there is usually no help available, no sexual counseling, no adequate reassuring information which would equip the young person and support and encourage him not to avoid sex but to arrange subsequent corrective sexual experiences for himself. These are necessary to rapidly extinguish the anticipatory anxiety and the tendency to avoid situations where there might be a repetition of the fear and shame. If adequate help were available to young persons at this critical point in their sexual development, many serious sexual problems could probably be prevented. (Kaplan, 1974b, p. 179)

She has also stated that people trained in human sexuality and the more superficial causes of dysfunction may be qualified to do preventitive education and counseling (Kaplan, 1974a).

The college sex educator may be viewed in two ways which are particularly relevant to counseling. First, the educator should be a source of accurate information. Second, open communication related to many aspects of human sexuality should be established in the classroom. Furthermore, students with problems may feel much more comfortable about "dropping into the office" than they would about establishing contact with other professionals in the community.

The problem of seeking sexual counseling is compounded by the present status of the field of sex therapy and the paucity of individuals "qualified" to engage in sex therapy. Furthermore, physicians rarely have adequate time for helping individuals with sexual problems.

Thus, with some confidence and some trepidation the classroom teacher of human sexuality may choose to engage in preventive counseling with individuals who are apparently free of psychopathology and whose relationship is apparently sound. Clearly, the sex educator must make an "educated judgment" in these realms as there do not appear to be precise criteria upon which this kind of a decision is to be made. Instead the educator must rely upon personal knowledge of the causes of dysfunction in this assessment.

In order to make these judgments the educator must clearly

understand those factors related to sexual behaviors, the syndromes which reflect negative factors influencing sexual behaviors, the principles underlying treatments of dysfunctions and the treatment techniques. Then, the educator must discriminate between deep-rooted and superficial syndromes and treatments which he can use and those which he is quite unqualified to attempt. An awareness of these factors enables this person to evaluate the needs of the individuals involved and help them find other sources of professional help.

Sex Therapy Models

Following are models of sexual dysfunctions and their treatments. (Kaplan, 1974b). The area in which the educator may attempt preventitive counseling is "Immediate Causes of Sexual Dysfunction." Others clearly require skills of a physician, a psychologist, a psychiatrist, or perhaps a team of these individuals.

IMMEDIATE CAUSES OF SEXUAL DYSFUNCTION

Positive Factors Influencing Sexual Behavior

- Education.
- Communication.
- Acceptance of responsibility for one's own sexuality.
- Abandonment.
- Giving to get.

Negative Factors Influencing Sexual Behavior

- Ignorance related to sex.
- Failure to communicate.
- Fear of failure.
- Emphasis on performance.
- Defense against erotic feelings.
- Excessive need to please partner.

Syndromes

- Creation of anti-erotic environment.
- Partners not pleasing to one another.
- Ineffective, mechanical, goal-oriented lovemaking.
- Spectatoring.
- Performance anxiety.
- Anticipation or rejection by partner.

Principles Underlying Treatment

- Permission-giving relieves guilt and facilitates effective behavior.
- Techniques of couple may have been mechanical and hurried.
- Removal of fear of failure facilitates sexual behavior and demand for performance.
- Removal of spectatoring removes defense to effective sexual behavior.
- Failure to communicate perpetuates a debilitating sexual system.

Treatment

- Couple is taught more effective techniques and is encouraged to use them.
- Couple is instructed in the use of sensate focus exercises for purpose of increasing pleasure.
- Couple is instructed in the use of non-demand pleasuring exercises.
- Removal of debilative intrapsychic and transactional dynamics is attempted in conjoint counseling sessions.
- Sensate focus and pleasuring exercises remove superficial perceptual defenses.
- Open system of communication (in which fears, desires, shames, and needs are shared) is created in conjoint therapy.

INTRAPSYCHIC CAUSES OF SEXUAL DYSFUNCTION

Positive Factors Influencing Sexual Behavior

Guilt-free giving of erotic pleasure.
Guilt-free receiving of erotic pleasure.

Negative Factors Influencing Sexual Pleasure

Prohibitive childhood experiences and education.
Moralistic/religious belief that sexual pleasure is sinful.
Lack of socialization with parents and peers.

Syndrome

Conflict between sexual wishes and fear of punishment for engaging in sex.
Negative consequences associated with lovemaking.
Anxiety in lovemaking with mobilization of defenses against arousal.

Principles Underlying Treatment

Resolution of "here and now" conflict removes obstacles to effective sexual functioning.
Resolution of deep oedipal conflicts is avoided whenever possible.

Treatment

Pleasuring exercises and mutual erotic stimulation exercises are prescribed.
Insight therapy occurs in counseling sessions.

DYADIC CAUSES OF SEXUAL DYSFUNCTION

Positive Factors Influencing Sexual Behavior

Partner acceptance.
Partner warmth.

Negative Factors Influencing Sexual Behavior

Partner rejection.
Partner hostility.

Syndrome

Hostility.
Fear of rejection or abandonment by partner.
Transference of old family relationships into dyad.
Lack of trust.
Use of sex in power struggles.
Contractual disappointments in role assignments.
Sexual sabatoge of partner.
Lack of communication.

Principles Underlying Treatment

Commitment and cooperation of partners is required for treatment.
Rage at spouse and fear of abandonment (his or her leaving) perpetuate sexual dysfunction.

Treatment

Therapy is conducted for two partners who demonstrate love for one another.
Resolutions of interactional problems occurs in order to modify sexual system.
Sexual ambience is changed to remove pressure and demand from system.

LEARNED CAUSES OF SEXUAL DYSFUNCTION

Positive Factors Influencing Sexual Behavior

Sexual response associated with positive contingencies.
Lack of traumatic events e.g. rape.
Relaxation.
Participation between consenting adults out of the sight of others.

Negative Factors Influencing Sexual Pleasure

Sexual response associated with negative contingencies.
Traumatic events e.g. rape.
Fear of "being caught."
Threatening, humiliating, or unpleasant events following sexual expression.

Syndrome

Fear of injury for being discovered.
Feelings of guilt.
Anticipated criticism, humiliation, or rejection of partner.

Principles Underlying Treatment

Removal of the rewards from sexual symptoms fosters sexual functioning.
Punishing undesired sexual reaction improves sexual functioning.
Extinguishing fear that is impairing sexual response facilitates behavior.

Treatment

Feared object is fantasized and relaxation is the reward.
Erotic pleasure derived from sexual tasks becomes reward for sexual responses.

Kapan stated that the overall objective of sex therapy was relief of the patients' sexual symptoms. Being able to relieve the difficulties required an accurate assessment or diagnosis of them as well as the establishment of objectives for treatment. The therapist selected a variety of techniques using psychotherapy and prescribing sexual techniques. The therapist carefully selected among the several modes according to the etiology of the dysfunction.

A Reality Therapy Model for the Human Sexuality Instructor

Inasmuch as most of the techniques of sex therapy require skills that the sex educator does not have, a model of Reality Therapy has been chosen for use by the educator (Baird et al, 1972).

The sex educator may be able to deal with the immediate causes of sexual dysfunction in individuals who are free of psychopathic behaviors and whose relationship is sound. Most of the techniques used by the sex counselor required training that educators typically have not had. On the other hand, Reality Therapy is often used by educators.

Reality Therapy is functional in counseling with students to help them change their behaviors. The role of the instructor is that of helping the student to identify his behavior and to establish a plan to change it. During the counseling session the teacher enables the student to make value judgments related to the behavior or to identify the consequences of his behavior.

The student is enabled to make a plan to change his behavior with counselor assistance.

In working with the student there are several principles operating to insure effectiveness of the therapy. First, improvement in the experience (this case a sexual one) makes the individual feel better. The "therapist" shows through his behaviors that he cares for the students and that they are persons of worth. The "therapist" is working in the present with the reality as it exists at that time. The therapist does not ask for or accept excuses by asking "why?" Finally, the individuals, not the "therapist" are responsible for behavior and plans for change are largely in their hands.

Summary

The college level sex educator is viewed by the student as a professional individual with accurate information about sex as well as a person with whom communication regarding sex is possible. Problems of sexual dysfunction are prevalent among students but in many instances the problems are not of long duration. Preventitive counseling using a reality therapy model may be possible for the sex educator.

Clearly, the sex educator is not entitled to use of many of the techniques of sex therapy although a knowledge of the etiology of sexual dysfunction, symptoms of dysfunction and principles and techniques for treatment helps in assessment of type of professional care that is required for the individual.

Conclusion

Premarital intercourse among youth is definitely increasing. It is influenced by many social, psychological, and physiological factors. Sexual dysfunction is common in the general population. Techniques of sex therapy have been developed for treatment of sexually dysfunctional individuals. For individuals who have a sound relationship and who are free of psychopathological behaviors preventitive counseling using a reality therapy model related to immediate causes of sexual dysfunctions, may prevent serious long-term sexual dysfunctions. Understanding of the techniques of sex therapy enable the educator to modify tactics for counseling use and to make referrals when necessary.

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